COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:019, Pharmacy Services

Summary of Material Incorporated by Reference
Amended August 26, 2004 via Appropriations and Revenue Committee

(1) "MAP-573 Kentucky Medicaid Program Request Form for Drugs Prior Authorized for Nursing Facility Residents, December 1995 edition", is a one (1) page form that is being deleted from the material incorporated by reference. The information provided on the form shall now be submitted electronically.

(2) "MAP-82001 Drug Prior Authorization Request Form, January 30, 2003, edition". The prior form was revised to insert a place for Medicare Part B request information and to add a fax number for nursing facility requests. The form is utilized to request a prior authorization of a medication for a Medicaid recipient and consists of one (1) page.

(3) "MAP-82101 Brand Name Drug Override Request Form, March 3, 2003, edition". The prior form was revised to add a fax number for nursing facility requests and to expound upon medical justification requirements. The form is utilized to request a prior authorization for a brand name medication and consists of one (1) page.

(4) "MAP-012802 PPI and H2 Blocker Request Form, March 3, 2004 edition", replaces the January 28, 2002 edition. The revised form eliminates prior authorization information from a box toward the top of the page and inserts PPI requests information as well as adds a fax number for nursing facility requests. The form is utilized to request prior authorization for proton pump inhibitors and H2 receptor blockers. This form consists of one (1) page.

PPI and H2 BLOCKER REQUEST FORM

(MAP-012802, revised 03-03-04

bmitted by: [ ] Prescriber [ ] Pharmacy

pproval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to 866-863-8803 (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

_____

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

NAME OF DRUG REQUESTED	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)

Yes	No	Unknown	
[ ]	[ ]	[ ]	Is the request for brand name only (if generic is available)? If yes, prescriber must handwrite *Brand Necessary* & sign beside it:
[ ]	[ ]	[ ]	Has the requested drug been prior authorized previously?
]	[ ]	[ ]	Has endoscopy or an esophagram been done? Give date of exam & results: _____
]	[ ]	[ ]	For PPI requests: Is the request for initial or new treatment with a PPI?
.]	[ ]	[ ]	For PPI requests: Has the recipient has been treated for more than 12 weeks with PPIs during the past 6 months?

DIAGNOSIS (Check one)

[ ] Barrett's esophagitis
[ ] Duodenal ulcer, acute or recurring
[ ] Esophageal stricture
[ ] Gastric cancer, current or previous
[ ] Gastric ulcer, acute or recurring
[ ] GERD (Gastroesophageal reflux disease)
[ ] GERD grade III-IV, continuing symptomatic
[ ] GERD, atypical with chronic laryngitis, hoarseness, or cough due to reflux
[ ] *Helicobacter pylori* eradication protocol
[ ] NSAID gastropathy
[ ] Schatzki's ring
[ ] Zollinger-Ellison syndrome
[ ] Other (specify)_____

PPI or H2 blocker Therapy (List all PPI's and H2 blockers used in the past 3 months.)	Dosage Form	Strength	Directions for Use	Date treatment started	Date treatment ended

CURRENT MEDICATIONS _____

MEDICAL JUSTIFICATION_____

_____

_____

LEAVE THIS SECTION BLANK

907 KAR 1:019

Material Incorporated by Reference

Clean

MAP-82001 Drug Prior Authorization Request Form
(January 30, 2003 edition)

"MAP-82101 Brand Name Drug Override Request Form
(March 3, 2003 edition)

"MAP-012802 PPI and H2 Blocker Request Form
(March 3, 2004 edition)

Dirty

MAP-573 Kentucky Medicaid Program Request Form for Drugs
Prior Authorized for Nursing Facility Residents
(December 1995 edition)

"MAP-82001 Drug Prior Authorization Request Form
(February 8, 2002 edition)

"MAP-82101 Brand Name Drug Override Request Form
(February 8, 2002 edition)

"MAP-012802 PPI and H2 Blocker Request Form
(January 28, 2002 edition)

Filed: August 26, 2004

BRAND NAME
DRUG REQUEST FORM
(MAP-82101, revised 3/3/2003)

FAX to **866-863-8803** (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

Use this form to request a brand name drug when generic forms of the drug are available. Please provide medical justification why the individual can not be appropriately treated with the generic form of the drug.

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

	Brand Name Drug Requested (Use separate form to request more than 2 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA
1						
2						

	Has patient recently been treated with generic forms of the requested brand name drug? Circle yes or no. Specify dosage and length of therapy with generic forms.	Hand write "Brand Medically Necessary"	Prescriber Signature
1	Yes No		
2	Yes No		

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (Indicate why the individual's medical condition cannot be adequately treated with generic forms of the drug. Provide any appropriate laboratory tests, blood levels, dates generic drugs prescribed by current/previous providers, or any other medical documents to support the request for the brand name drug.)

_____

_____

_____

_____

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	

DRUG PRIOR AUTHORIZATION REQUEST FORM (MAP-82001, rev. 1/30/2003)

FAX to 866-863-8803 (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

REQUEST TYPE (please check): ☐ **PRIOR AUTHORIZATION** ☐ **MEDICARE PART B OVERRIDE** ☐ **QUANTITY LIMIT OVERRIDE**

☐ OTHER _____

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

DRUG NAME (Use extra forms for more than 4 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)
#1						
#2						
#3						
#4						

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

MEDICAL JUSTIFICATION (including drugs already tried) _____

MEDICARE PART B REQUEST REASON (PLEASE CHECK ONE): (A copy of the Medicare EOB denying coverage must accompany each request)

☐ RECIPIENT IS NOT MEDICARE PART B ELIGIBLE

☐ RECIPIENT IS TAKING THE MEDICATION FOR AN INDICATION THAT IS NOT COVERED BY MEDICARE

☐ OTHER (PLEASE EXPLAIN ABOVE)

☐ DRUG DOES NOT MEET MEDICARE COVERAGE CRITERIA

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	
DRUG #3	
DRUG #4	

Highlighted Fields are Medicare POS - Mandatory Fields